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In the Supreme Court of the United States

OCTOBER TERM, 1998

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, ET AL., PETITIONERS

v.

DELORES SCOTT SULLIVAN, ET AL., RESPONDENTS

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

REPLY BRIEF FOR PETITIONERS

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RULE 29.6 STATEMENT

Pursuant to Rule 29.6, all parent companies and nonwholly owned subsidiaries of each of the corporate petitioners are listed in the Petition for a Writ of Certiorari at ii-iii and the Brief for Petitioners at ii.

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REPLY BRIEF FOR PETITIONERS

In our opening brief, we showed that petitioners' decisions to invoke utilization review and defer payment of contested bills for workers' compensation medical care, although authorized by Pennsylvania law, are not "fairly attributable to the State." Neither the payment of medical bills for injured workers nor the decision to dispute a given therapy has ever been the State's function or duty. Postponing payment of disputed claims, moreover, is commonplace in private business, and the State here neither compels nor encourages such delays. In short, the Fourteenth Amendment's limitations, which govern deprivations of property *by the state*, do not apply in this case.

Respondents' first answer is to suggest that, because this case is a "facial" or "direct" challenge, the Court may dispense with its traditional analysis and find state action solely on account of the existence of a body of workers' compensation law, without regard to either petitioners' identity as private entities or the particular actions being taken in response to that law. Alternatively, they offer an "all things considered" theory of state action, under which the principles established by this Court's decisions are merely "factors" or "guides," to be applied "flexibly" in light of the "factual subtleties" of each "unique" case. Accordingly, respondents cite a laundry list of factors said to add up to significant state involvement in the Pennsylvania workers' compensation scheme.

Neither of these theories is supported by precedent. The notion that a "facial" challenge must succeed because the State enacted and administers the governing regulatory scheme flies in the face of this Court's repeated holdings that state action requires *both* state authorization *and* significant state involvement in the particular action being challenged. As for the claim that the State's involvement in regulating workers' compensation insurance somehow makes the State responsible for insurers' decisions to delay payment for disputed treatment pending utilization review, such an approach would turn virtually every decision of a regulated entity into state action.

Respondents' due process arguments are equally unavailing. They lead with a frivolous argument that the due process issue on

which this Court granted certiorari — the constitutionality of Pennsylvania's payment suspension provision — is moot because petitioners chose not to seek review of, and the Commonwealth has modified its procedures to comply with, other portions of the due process holding below. On the merits, respondents offer no real answer to a number of our contentions: that individuals are entitled to due process hearings only with respect to their own eligibility for benefits and not with respect to payments to third-party providers; that traditional practice under state and federal law confirms the basic fairness of Pennsylvania's procedures; and that submission of a bill is akin to an application for benefits and employees have no vested interest in payment for unreasonable or unnecessary care. The only point they seriously put forward — that permitting insurers to delay payment during utilization review does not survive the *Mathews* balancing test — does not withstand scrutiny.

I. State Action

A. A "Direct Challenge" To The Constitutionality Of Pennsylvania's Workers' Compensation Law Is Subject To Traditional State Action Analysis

In the opening pages of their argument, respondents advance the remarkable claim that traditional state action analysis does not apply here because this case involves a "facial" or "direct challenge to the constitutionality of a state statute." Resp. Br. 18. In such cases, respondents argue, the Court "by necessity" must "focus on the state statute and its underlying policy," without regard to either "the identity of the defendant" or the particular "act or decision by a private actor or entity who is relying on the challenged law." *Id.* at 16. Indeed, respondents suggest that there is no "need to address the state action question, as the facial attack apparently render[s] that unnecessary." *Id.* at 17 n.20.

Respondents' theory lacks any support in this Court's precedents. No decision of this Court has ever held that a facial challenge obviates the need to address state action. Indeed, the

terms "facial," "direct," and "indirect" appear nowhere in those decisions — not even in the cases cited by respondents.[1]

Moreover, respondents' approach is foreclosed by this Court's repeated instruction that state action requires *both* that a "deprivation must be caused by the exercise of some right or privilege created by the State or by a rule of conduct imposed by the State" *and* that "the party charged with the deprivation * * * be a person who may fairly be said to be a state actor." *Lugar* v. *Edmondson Oil Co.*, 457 U.S. 922, 937 (1982); accord *Flagg Bros., Inc.* v. *Brooks*, 436 U.S. 149, 156 (1978) (one "must establish not only that [the putative state actor] acted under color of the challenged statute, but also that its actions are properly attributable to the State"). Respondents' theory would contravene these precedents by rendering the second part of this inquiry — whether action taken in response to the governing rule is fairly attributable to the State — irrelevant.

Under respondents' theory, a plaintiff challenging the private conduct of another party need only characterize the claim as a "facial challenge" to the statute under which that party acts, and state action limitations disappear. Thus, if the plaintiff in *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974), had only thought to bring a "direct" or "facial" challenge to the statute permitting the private utility to terminate electrical service without giving the customer notice and the opportunity to be heard, the case would have come out the other way. If the plaintiffs in *Blum* v. *Yaretsky*, 457 U.S. 991 (1982), had simply characterized their action as a "facial" challenge to the statute permitting transfer to a different nursing home, they would have prevailed. State action jurisprudence simply does not turn on such semantics.

Respondents' fallacy is in thinking that the constitutionality of a statute can be evaluated independently of the status of the party acting pursuant to the statute. But the Due Process Clause only

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[1] It is not obvious that the plaintiffs' complaint was facial in nature. The Amended Complaint contains more than 150 allegations pertaining to the application of the statute to named individuals. See ¶¶ 92-264, J.A. 24-42.

applies when life, liberty, or property is taken away *by the state*.[2] Of course, "the enactment and enforcement of an unconstitutional state law" — by the state — "is state action" (Resp. Br. 25), but it is not state action for a private party to take advantage of rights granted by a statute, unless that party can "fairly be said to be a state actor." *Lugar*, 457 U.S. at 937.

A simple example involving unquestionably private conduct may help to expose the fallacy. Surely no one doubts that a private employer's dismissal of an at-will employee is private action, and that the Due Process Clause does not of its own force require the employer to give the employee advance notice or the opportunity to be heard. Suppose, however, that a State decided to enact worker-protection legislation limiting the employer's power to dismiss its employees. Suppose the statute required that the employer file a form with the State before dismissing the employee and submit the matter to an independent "dismissal justification review organization." That organization would determine whether the dismissal was justified and, in the event that it was not, reinstate the employee with back pay. Now an employee brings a constitutional challenge, claiming that it violates due process to allow the employer to dismiss him without advance notice and an opportunity to be heard. He claims that the employer is constitutionally obligated to keep him on the payroll until *after* the dismissal justification review has been completed.

In that example, as here, it should make no difference whether the case is characterized as a facial challenge or as an as-applied challenge. A private employer dismissing an employee is not a state actor no matter how the constitutional challenge is framed. The statute — which expands the employee's rights compared to those he would have if the State had not acted — cannot, therefore,

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[2] Respondents' observation (at 17) that, in cases where this Court has "found that the law violates the procedural due process or the equal protection clause, it has invariably found that the private actor or entity invoking or relying on the unconstitutional law is a state actor" confuses cause with effect. The Court could not hold that due process or equal protection had been violated unless the party whose behavior is being challenged is a state actor.

be held to violate the Due Process Clause. As the Court explained in *Flagg Bros.*, "[i]t would intolerably broaden * * * the notion of state action under the Fourteenth Amendment to hold that the mere existence of a body of property law in a State, whether decisional or statutory, itself amounted to state action." 436 U.S. at 160 n.10.

B. The Miscellaneous Factors Identified By Respondents Do Not, Individually Or Collectively, Demonstrate State Action In This Case

Perhaps aware that this Court's decisions will not sustain the claim that styling their lawsuit as a "direct" challenge allows them to avoid the strictures of traditional state action analysis, respondents resort to a "totality of the circumstances" or "all things considered" theory of state action. Resp. Br. 32.[3] But, as we show below, the various elements identified by respondents — the filing of a form, the State's alleged "supervision" of private UROs, the claim that payment for medical care is a "public benefit" or "vested state entitlement," the State's and insurers' mutual interest in cost containment, the "exclusivity" of the system, and the involvement of state personnel who administer the system — do not, individually or collectively, warrant the conclusion that the decision to invoke utilization review and withhold payment is state action. We consider their arguments in turn.

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[3] Respondents claim that the analysis in our opening brief is inconsistent with *Edmonson* v. *Leesville Concrete Co.*, 500 U.S. 614 (1991). Resp. Br. 31-33. In our opinion, the three factors discussed in *Edmonson* are roughly equivalent to the tests for state action employed in this Court's other cases, expressed in slightly different language. Thus, on the "Government's Assistance and Benefits," see Pet Br. 22-25; on "Traditional Government Function," see Pet. Br. 17-20; and on "Aggravation by Unique Incidents of Governmental Authority," see Pet. Br. 22-25. We do not believe that *Edmonson* should be read as impliedly overruling *Jackson*, *Blum*, *Rendell-Baker* v. *Kohn*, 457 U.S. 850 (1982), or the other decisions on which we rely, which are far closer to this case in their factual circumstances than *Edmonson*.

1. Respondents' Claim That The Decision To Invoke Utilization Review Receives Overt State Assistance And Encouragement

Respondents' central theme is that the State's mechanisms to *impede* insurers' behavior — its involvement in rejecting "requests" for utilization review, and in penalizing insurers who postpone payment without filing such requests — amount to "the overt *assistance* of the state" and compel a finding of state action. Resp. Br. 26 (emphasis added). "Like the non-claim statute involved in *Tulsa* [*Professional Collection Services, Inc.* v. *Pope*, 485 U.S. 478 (1988)]," they argue, an insurer's decision to withhold payment "is not self-executing." *Ibid.*

This argument confuses regulation with assistance. Undoubtedly, the insurers' right to defer payment of a disputed claim (see Pet. Br. 25 n.14) has been curtailed by state law. The insurer is required to file a form with the State,[4] to submit to a state-approved utilization review procedure,[5] to pay the costs of that procedure, and to pay 10% annual interest on any bill for disputed

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[4] This Court has made clear that a private party does not become a state actor on account of being required to file a form with a state agency. See *Blum*, 457 U.S. at 1006-07 (where "[private actors], and not the forms, make the decision about whether the patient's care is medically necessary," one "cannot say that the State, by requiring completion of a form, is responsible for the [private actor's] decision"); *Jackson*, 419 U.S. at 354 (rejecting a claim that the State "specifically authorized and approved" a practice merely because it appeared in a tariff "filed with the Public Utility Commission" for its approval or disapproval). In this case, the requirement of filing a form is especially inconsequential, since the form is reviewed only for completeness; the State makes no judgment about the substance of the insurer's request for utilization review. See Pet. Br. 22-23.

[5] Respondents emphasize the State's role in supervising and setting standards for UROs. See Resp. Br. 28. That might be relevant if the issue were whether URO decisions are "state action," but it is irrelevant to whether the insurer's decision to seek utilization review and postpone payment of disputed bills is state action. Even if utilization review were performed by a state agency, the insurer's decision would remain private.

medical care that is ultimately determined to be reasonable and necessary. But this cannot be described as "assistance"; it is state regulation of what would otherwise be a self-executing business decision.

Respondents' similar argument (at 38-40) that insurer payment decisions are state action because they are "aggravate[d] by unique incidents of governmental authority" fails for the same reason. The "unique incident" of governmental authority cited by respondents is the existence of Pennsylvania's regulatory scheme governing disputes over the reasonableness and necessity of treatment. The regulatory scheme does not put the State's imprimatur on insurers' decisions; rather, it constrains insurers' previously unfettered business judgment.

Tulsa Professional, on which respondents principally rely (see Resp. Br. 26), is in marked contrast. That case involved a due process challenge, based on inadequate notice, to an Oklahoma nonclaim statute that barred creditors from bringing claims against an estate if not presented to the executrix within two months of the published commencement of probate proceedings. Without the *assistance* of both the state statute and the probate court, the executrix would have been powerless to bar creditors' claims. "The probate court is intimately involved throughout, *and without that involvement the time bar is never activated.*" 485 U.S. at 487 (emphasis added). Here, by contrast, had the State not gotten "involved," petitioners would have had more freedom — not less — to withhold payment of disputed sums.

For similar reasons, respondents' reliance on cases such as *Nixon* v. *Condon*, 286 U.S. 73 (1932), *Smith* v. *Allwright*, 321 U.S. 649 (1944), *Evans* v. *Newton*, 382 U.S. 296 (1966), and *Edmonson* v. *Leesville Concrete*, 500 U.S. 614 (1991), is misplaced. Each of those cases involved conduct — control over elections (*Nixon* and *Smith*), management of municipal parks (*Evans*), and selection of juries (*Edmonson*) — in which private parties had no authority to engage without delegation of authority from the State. As the Court explained in *Nixon*, those running the election possessed the power to exclude black voters from a primary election "not by virtue of any authority delegated by the party, but by

virtue of an authority originating or supposed to originate in the mandate of law." 286 U.S. at 84.

2. Respondents' Claim That Workers' Compensation Is A "Public Benefit" And "Constitutional Right"

Respondents also argue that the nature of workers' compensation makes the decisions of employers and insurers attributable to the State. The argument proceeds in two steps. First, they say that workers' compensation medical benefits are a "public benefit" or "state entitlement" to which all workers have a "constitutional right." See Resp. Br. 2, 5, 17, 23-24, 26, 27. Insurers who provide it, therefore, "are not operating in a private business sphere, but are delivering public benefits which are constitutionally protected from arbitrary deprivations." *Id.* at 27. Second, they say that the State may not, by delegating to insurers its responsibility to provide such benefits, avoid the requirements of the Constitution and attempt "to do indirectly what the state cannot do directly." *Id.* at 29. The second of these arguments rests on the first, and the first topples upon any serious scrutiny.

Workers' compensation medical benefits are neither "public" nor "constitutional" within the ordinary meaning of those terms. They are not funded or provided by the State, and the legislature could repeal them tomorrow, relegating workers to their remedies in tort. Indeed, respondents' argument would come as some surprise to Pennsylvania employers, who for years have shouldered the entire financial burden of providing workers' compensation and are under the impression that doing so is their duty under state law. The State has long *mandated* the private provision of such benefits, but it has never *assumed that responsibility*. See Pet. Br. 18-19. Respondents' "delegation" claim — that entrusting to insurers the provision of workers' compensation medical benefits, and the "right" to withhold payment for such benefits, is an attempt to evade the Constitution's requirements — thus rests on a false premise. Workers' compensation medical benefits are not a public benefit, and the Constitution does not require their provision. Thus, it makes no sense to say that the Commonwealth has "evaded" its duties by delegating "its" responsibilities to private parties.

Even if Pennsylvania *had* assumed the responsibility of funding workers' compensation benefits, that would not, without more, render insurers' independent decisions to invoke utilization review and withhold payment state action. Medicaid is a state-funded program, but this Court has held that private decisions, made during utilization review, to transfer Medicaid patients to lower levels of care do not implicate constitutional protections. *Blum*, 457 U.S. at 1012.

3. Respondents' Claim That Petitioners Are Performing An "Exclusive Public Function"

The foregoing points also illustrate the fallacy of respondents' claim that petitioners are performing a "traditional" or "exclusive" public function. Resp. Br. 37. For example, respondents contend that, because "the state guarantees the delivery of medical care to the injured worker by imposing upon the employer the obligation to pay for it," the "provision of workers' compensation benefits in Pennsylvania is * * * an exclusive state function." *Id.* at 36. But respondents' admission that it is *employers* who have always been obligated to provide workers' compensation itself demonstrates that providing such benefits is not a "public function" — let alone a "traditional" or "exclusive" one.[6] As the Court explained in *Jackson*, "public function" analysis does not apply where the law "imposes an obligation to furnish service on [a private entity]," but "imposes no such obligation on the State." 419 U.S. at 352-53.

Respondents likewise maintain that the public function test is satisfied because "the state has had exclusive control over the stoppage of an injured worker's medical benefits since 1984" and

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[6] Respondents suggest that "[a]fter *Edmonson* [v. *Leesville Concrete*] much debate ensued as to whether or not the public function test still required exclusivity." Resp. Br. 44. We believe that the weight of this Court's authority holds that exclusivity is a central part of the public function test. See *Blum*, 457 U.S. at 1005; *Jackson*, 419 U.S. at 357; *Flagg Bros.*, 436 U.S. at 158-61. We hasten to add, however, that the Court need not resolve the debate in this case: neither providing workers' compensation insurance nor withholding payment of disputed claims is typically a public function at all, much less an *exclusive* public function.

insurers were thus not permitted to delay payment of bills for disputed treatment without the approval of a workers' compensation judge until Act 44 was enacted in 1993. Resp. Br. 36, 45. Yet for most of the life of the workers' compensation system,[7] power to defer payment of disputed bills rested with insurers. The fact that the State assumed control for a brief period does not mean that for constitutional purposes this has become an inherently or exclusively state function. Withholding payment for disputed claims is a routine aspect of private contractual relations in the insurance business.[8]

4. Respondents' Claim That The Pennsylvania Act Satisfies The "Joint Participation" Test

Throughout their brief, respondents sound the refrain that invoking utilization review is akin to "promoting the state's policy of cost containment." Resp. Br. 17; accord *id.* at 18, 31. They further develop this argument in the "joint participation" section of their brief (at 40-44). They contend that, because "[t]he state's policy of cost containment was intended to further its own interest in attracting business to Pennsylvania," the legislature "ensured that employers and their insurers would derive economic benefit directly from the utilization review provisions, who stand to save money each time they invoke the process." *Id.* at 42. "The employer's decision to invoke review in any particular case, therefore, is inev-

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[7] In fact, contrary to respondents' contention, the change came about in 1978, when the Pennsylvania legislature amended the statute to require payment for disputed care pending administrative review. See *Fuhrman* v. *Workers' Comp. App. Bd.*, 515 A.2d 331, 333-35 (Pa. Commw. Ct. 1986), appeal dismissed, 540 A.2d 267 (Pa. 1988). The relevant event in 1984 was the district court decision in *Baksalary* v. *Smith*, 579 F. Supp. 218 (E.D. Pa. 1984), appeal dismissed, 469 U.S. 1146 (1985), which pertained to indemnity rather than medical benefits.

[8] Respondents make much of the fact that workers cannot "opt out" of the Pennsylvania system. See Resp. Br. 6 n.9, 7, 24 n.25. That, however, does not render any of the participants in the system state actors. Some states have made no-fault insurance the exclusive remedy for automobile injuries and do not permit accident victims to opt out. That does not make no-fault insurers or their policyholders state actors.

itably intertwined with the state's interest, even though the state is not consulted in advance." *Id.* at 42, 43.

This argument has no logical stopping point: the State benefits in some abstract way *anytime* a private party acts in a manner consistent with the law. Does complying with traffic laws make an automobile driver a "promoter of the State's policy of safe driving"? Does complying with minimum wage laws make a private employer the State's "promoter of a fairly compensated workforce"? If a company chooses to invest in one line of business rather than another because the State has provided tax incentives, does that fact make the company's decision — and not just the State's enactment of the statute — state action?

In *Blum*, this Court rejected the claim that the State's extensive funding and power to license rendered it a "joint participant" in private nursing homes' discharge and transfer of Medicaid patients. 457 U.S. at 1010-11. *Blum* thus confirms that this Court's "joint action" cases require far greater mutual benefit than is present here.

Respondents attempt to distinguish *Blum*, stating (at 43):

> Although the utilization review [in *Blum*] was undertaken in accordance with state regulations, and the state was ultimately notified by the nursing home and adjusted the payment to the nursing home accordingly, there was absolutely no interaction with the state until the decision to perform utilization review had been made, the review completed, and the ultimate decision as to the appropriate level of care determined. The procedures were entirely self-executing.

This is a very selective reading of the facts in *Blum*. Virtually every factor identified by respondents to support their claim of state action was present in greater force in *Blum*. For example, respondents make much of the fact (at 26) that state personnel are involved in the review and processing of forms notifying the State that an insurer is invoking utilization review, yet this fact was also present in *Blum*. 457 U.S. at 1006-07, 1010. Likewise, they make a great deal of the fact that state personnel "supervise" or "monitor" UROs (at 28), but that too was true in *Blum*. 457 U.S. at 1008, 1009 n.21. Respondents say (at 42) that the State stands to gain from the invocation of cost containment procedures such as

utilization review, but in *Blum* the State benefited far more directly, in the form of decreased Medicaid expenditures. 457 U.S. at 994, 1011. The decision to invoke utilization review here is left entirely to the business judgment of insurers, whereas in *Blum* both the State and the private facility were required — at risk of losing federal funding — to safeguard against all unnecessary care. *Id.* at 994 n.3, 1007-08. It is said here (Resp. Br. 5) that workers' compensation medical benefits are a "public benefit," but in *Blum* it was undisputed that the Medicaid benefits at issue were public in nature. 457 U.S. at 993-94. In short, if *Blum* did not involve state action, it is inconceivable that petitioners' actions in this case are subject to constitutional review.

II. Due Process

A. This Court Should Resolve The Due Process Question

As a preliminary matter, we stress the importance of resolving the due process question even if the state action issue is decided in petitioners' favor. On this point (putting aside a frivolous mootness issue, discussed below), all parties agree. If this Court reversed on the state action issue but left the due process holding intact, it would — in respondents' words (at 2 n.4) — "wreak havoc in Pennsylvania's workers' compensation system." Workers' compensation involves private and governmental employers in an integrated system, with sharing of the risks of paying for unreasonable or unnecessary medical care. It would not be practicable to have different rules apply to each. This Court granted certiorari on both questions presented, and decision in petitioners' favor on the first would *not* make resolution of the second unimportant.

B. The Due Process Question Is Not Moot

Respondents argue (at 3 & n.6) that the due process question on which this Court granted certiorari is moot.[9] They note that in response to the Third Circuit's decision the Commonwealth has "changed its procedures to ensure that injured workers subject to utilization review are provided with a notice which informs them

[9] Respondents made their mootness argument in their Brief in Opposition (at 19), and the Court nevertheless granted certiorari without limiting the questions presented.

of their opportunity to submit a written statement to the utilization reviewer and that if the review is adverse, their medical benefits may be lost." *Id.* at 3. They further contend that the "Commonwealth is not defending the pre-*Sullivan* statute" and is no longer a participant in these proceedings. *Id.* at 3 & n.6. Neither of these arguments establishes mootness, although the latter does misstate the record.

We concede that controversy over the requirements of notice and an opportunity for the employee to submit a written statement to the utilization reviewer would be "moot" — because we chose not to seek further review of those aspects of the decision below. Pet. Br. 9.[10] But that does not detract from the justiciability of the question presented: whether insurers or employers may delay payment of disputed bills pending utilization review. The relevant provision of 77 Pa. Stat. Ann. § 531(5) has not been repealed,[11] and neither the petitioners nor the Commonwealth has conceded the statute's unconstitutionality. Petitioners have steadfastly challenged this part of the Third Circuit's holding throughout the litigation, and made it one of our two questions presented. The Commonwealth also petitioned this Court for review on the due process issue. *Butler* v. *Sullivan*, No. 98-161 (July 10, 1998). Despite denial of its cross-petition, the Commonwealth remains a party in this case. SUP. CT. R. 12.6. And although the Commonwealth has waived briefing and argument, it has noted that its "interests are generally aligned with those of the petitioners." Letter from John G. Knorr, III, Pennsylvania Chief Deputy Attorney General, to Sandy Nelsen, Merits Clerk, at 2 (Nov. 25, 1998). Any suggestion

[10] Although we did not seek review of these issues, we do not agree with or concede the correctness of the Third Circuit's analysis of them.

[11] Respondents appear to believe that, because the Third Circuit struck down a provision of Section 531(5) as unconstitutional, this Court cannot review its constitutionality unless the Pennsylvania legislature reenacts it. Resp. Br. 3-4 & n.6. Respondents cite no authority for this proposition, which defies both logic and precedent. See, *e.g.*, *Timmons* v. *Twin Cities Area New Party*, 520 U.S. 351 (1997); *Lambert* v. *Wicklund*, 520 U.S. 292 (1997).

that petitioners or the Commonwealth has conceded the due process issue before this Court is absurd.

Even if the Commonwealth had withdrawn its opposition to the Third Circuit's due process holding, its actions would not bar review. The decision of the Third Circuit precludes petitioners from taking advantage of the statute permitting delays in payment for disputed medical care pending utilization review. Petitioners have discontinued this practice only because their motion to stay issuance of the Third Circuit's mandate was denied. See *Sullivan* v. *Barnett*, No. 96-2140 (3d Cir. Apr. 21, 1998). Moreover, the School District of Philadelphia, which is likewise a party to this case and has filed a brief in support of petitioners, also presses the due process argument. Should the Third Circuit's due process holding be overturned, petitioners (and presumably the School District and other employers, both private and governmental) intend to resume delaying payment of bills for disputed care pending utilization review. The case is therefore not moot. *Firefighters Local Union No. 1784* v. *Stotts*, 467 U.S. 561, 569 (1984); *Coopers & Lybrand* v. *Livesay*, 437 U.S. 463, 465 n.3 (1978).[12]

C. Petitioners Are Not Required To Bring An "All-Or-Nothing" Challenge To The Due Process Holding

In a related argument, respondents assert that this Court may not review the due process question because the petitioners have not challenged the portions of the Third Circuit's holding requiring them to give workers greater notice of the potential consequences of utilization review and an opportunity to submit a written statement to the utilization reviewer. See Resp. Br. 3, 4 n.7, 21. As a result, respondents assert, "the Third Circuit's decision that the statute was unconstitutional must stand regardless of how this Court might view the other due process concerns raised by Petitioners." *Id.* at 21. This contention flies in the face of standard appellate practice, under which an appellant or petitioner is permitted to frame a question presented "as broadly or as narrowly as he sees fit." *Yee* v. *City of Escondido*, 503 U.S. 519, 535 (1992).

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[12] Of course, if this case had become moot, the proper disposition would be to vacate the judgment below and remand for dismissal of the case. *United States* v. *Munsingwear, Inc.*, 340 U.S. 36, 39 (1950).

In *Califano* v. *Yamasaki*, 442 U.S. 682 (1979), for example, the government petitioned for certiorari of the lower court's "holding that the Due Process Clause required a prerecoupment oral hearing" in a case involving overpayments under the Social Security Act, but it "did not request review of the holding that notice of recoupment was constitutionally defective." *Id.* at 692. Certiorari was granted, and the Court limited its review to the need for oral hearing. *Id.* at 695-97. Similarly, in *Baxter* v. *Palmigiano*, 425 U.S. 308, 324 n.6 (1976), the Court declined to address the holdings below with respect to notice and the requirement of a neutral hearing body where the petitioners chose not to challenge them on certiorari. There was no suggestion in either case that a concession of inadequate notice required affirmance of the lower court's holding *in toto* or dismissal of the writ.

There is nothing "advisory" (Resp. Br. 3) about the ruling petitioners seek. The Third Circuit struck down the provision of 77 Pa. Stat. Ann. § 531(5) that authorizes delay in payment of disputed bills. Pet. App. 25a ("Under our holding today we * * * sever the 'unless' clause from § 531(5) of the Act."). If and when that ruling is reversed, insurers and employers will be able to resume the practice, as authorized by the legislature.

D. Respondents' Arguments On The Merits Are Unconvincing

The vehemence with which respondents contest reviewability becomes explicable once one considers their defense of the Third Circuit's holding. The few arguments respondents bother to make — the most notable aspect of their brief is its non-responsiveness — do nothing to undermine petitioners' analysis.

Respondents simply ignore our contention that injured workers lack a protected interest because they are "indirect" beneficiaries under *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773 (1980). See Pet. Br. 32-35. Neither the respondents nor a single

one of their *amici* even cites *O'Bannon*, much less discusses its applicability to this case.[13]

Nor do respondents contest that withholding payment during disputes over workers' compensation coverage comports with traditional practice under state and federal law. See Pet. Br. 47-50. The only *amicus* in support of respondents to address the issue, the Pennsylvania Federation of Injured Workers, asserts that the widespread practice of the state and federal government should be disregarded because "workers' compensation statutes were adopted initially without regard for modern concepts of due process." Br. 17. That, however, begs the question, since "traditional practices" are the best evidence of what due process requires. Pet. Br. 47-48 (citing cases).

Respondents' contention that submission of a bill is not akin to an application for benefits is only marginally more responsive. Respondents assert that, because each named plaintiff has been found eligible for workers' compensation medical benefits (Resp. Br. 8 n.10), it follows that they are presumptively entitled to reimbursement for any and all care that they receive. *Ibid.*; see also *id.* at 1 (injured workers "have an undisputed property interest" in payment for disputed treatment); Br. Am. Cur. Pa. Trial Lawyers Ass'n *et al.* 8-9 (workers have "a legitimate claim of entitlement" to uninterrupted payment for medical care pending utilization review).

As we explained in our opening brief (at 35-38), however, this conclusion is erroneous. An injured employee's eligibility for workers' compensation benefits entitles him to reimbursement *only*

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[13] Respondents might be thought to address the *O'Bannon* distinction obliquely at 13 n.16, where they argue that they have a protected due process interest because provider "bills are merely the vehicle through which medical benefits are provided under the Act" and an injured worker's "treatment is ordinarily stopped" when bill payment is delayed. See also Resp. Br. 23-24. But that was true in *O'Bannon* as well, where Medicaid paid the nursing home directly on behalf of the patients and the "inevitable consequence" of suspension of Medicaid payments to the provider was "severe physical and emotional hardship" to some patients. 447 U.S. at 780, 784 & n.15.

for reasonable and necessary medical care. 77 Pa. Stat. Ann. § 531(1), (5). But determining whether medical care satisfies this standard cannot occur until the bill has been submitted or the provider or insurer has asked for pre-approval. Pet. Br. 37 & n.19. Until the insurer, employer, or utilization reviewer has decided that the care is reasonable and necessary, a worker has no vested entitlement to provider reimbursement.[14]

Finally, respondents' analysis of the competing interests under *Mathews* (at 21-24) does not withstand examination. Respondents seem oblivious to the need to control fraud and abuse in the medical field. They do not dispute that insurers are legally barred from recouping from the employee or the provider any payments made for unreasonable or unnecessary care. They do not dispute our contention that the decision below, if not reversed, would effectively negate the effects of utilization review and leave the system vulnerable to unscrupulous health care providers. They do not mention the Solicitor General's concern that the holding below would have similar disruptive effects for Medicare and Medicaid. Nor do they address our argument (at 41-43), echoed by the Solicitor General (U.S. Br. 27-28), that the incentives built into the current system make the risk of erroneous deprivation relatively slight. They ignore our citations to decisions of this Court upholding analogous systems in which payment of disputed bills is delayed pending resolution of the dispute. Pet. 45-47 (citing *United States Dep't of Labor* v. *Triplett*, 494 U.S. 715 (1990); *Heckler* v. *Ringer*, 466 U.S. 602, 619 (1984); *Schweiker* v. *McClure*, 456 U.S. 188 (1982)). None of these considerations seems to count in their analysis, but the due process balance cannot be conducted responsibly without attention to these issues.

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[14] Respondents are therefore incorrect when they assert (at 21) that "no one disputes that the challenged statute permitted a recognized property right to be disrupted without any pre-deprivation notice." We readily concede that, once a worker has been determined to be injured, he has a property interest in *reasonable and necessary* medical care; but he does not have a vested interest in reimbursement for *any particular course of treatment* until there has been a determination that it was reasonable and necessary. Accord U.S. Br. 21-24.

In our opening brief, we cited government statistics showing that almost 70% of the utilization reviews requested under the Act turned out to involve care that was unnecessary or unreasonable, at least in part, and that the procedures had produced significant savings. Pet. Br. 39-40, 43-44. Respondents do not challenge the accuracy of the statistics. Nevertheless, they argue (at 50 n.42) that this Court should not consider "numerous facts and statistics which were not in the record in the district court" because respondents' due process challenge was dismissed by the district court on a Rule 12(b)(6) motion. This Court, however, has frequently considered extra-record evidence in assessing the value of additional procedures, including government-compiled statistics of the type at issue here;[15] information gleaned from academic and scholarly sources;[16] and its own experience and common sense.[17] The statistics we cited are subject to judicial notice under Federal Rule of Evidence 201.[18]

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[15] See, *e.g.*, *M.L.B.* v. *S.L.J.*, 519 U.S. 102, 109 n.3 (1996); *Califano* v. *Yamasaki*, 442 U.S. 682, 697 (1979); *Califano* v. *Yamasaki*, No. 77-1511, Brief for Respondents 43-44, 46 (statistics considered over objection that they were outside the record); *Smith* v. *Organization of Foster Families for Equality and Reform*, 431 U.S. 816, 851 (1977); *Smith* v. *Organization of Foster Families for Equality and Reform*, Nos. 76-180, 76-183, 76-5193, 76-5200, Brief for State Appellants 20; *Richardson* v. *Perales*, 402 U.S. 389, 403 n.7 (1971); *Richardson* v. *Perales*, No. 108, October Term 1970, Brief for Petitioners 18 nn.7-8.

[16] See, *e.g.*, *Washington* v. *Harper*, 494 U.S. 210, 234 n.13 (1990); *Little* v. *Streater*, 452 U.S. 1, 7-8 (1981); *Parham* v. *J.R.*, 442 U.S. 584, 609 (1979); *Greenholtz* v. *Inmates of Nebraska Penal & Correctional Complex*, 442 U.S. 1, 14 (1979).

[17] See, *e.g.*, *Heller* v. *Doe*, 509 U.S. 312, 329-331 (1993); *Little*, 452 U.S. at 8; *Parham*, 442 U.S. at 609.

[18] See, *e.g.*, *United Steelworkers* v. *Weber*, 443 U.S. 193, 198 n.1 (1979); *Carey* v. *Population Servs. Int'l*, 431 U.S. 678, 690 n.8 (1977); *United States* v. *Bailey*, 97 F.3d 982, 985 (7th Cir. 1996); *United States* v. *Cecil*, 836 F.2d 1431, 1452 (4th Cir.) (noting "correct contention that courts may take judicial notice of official governmental reports and statistics"), cert. denied, 487 U.S. 1205 (1988); *Havens Steel Co.* v. *Randolph Eng'g Co.*, 813 F.2d 186, 189 (8th Cir. 1987); *Jamies* v. *Toledo Metro. Hous. Auth.*, 758 F.2d 1086, 1090 nn.3-4 (6th Cir. 1985).

Respondents accuse us of "grossly mischaracter[izing] the record" by describing the injured worker's interest in the challenged provision as involving "bills" — even though the statute they challenged uses precisely that terminology. Resp. Br. 23; compare 77 Pa. Stat. Ann. § 531(5). What is really at stake, according to respondents, is the provision of timely medical care. Resp. Br. 22 n.24 (citing *Stonebraker* v. *Workers' Comp. App. Bd.*, 641 A.2d 655, 659 (Pa. Commw. Ct. 1994)).[19] The fallacy in that argument was addressed in our opening brief (at 41-42).

Respondents seem to be suggesting that the workers' interests are especially harmed because they are prohibited from obtaining additional medical services with their own funds. See Resp. Br. 7, 24 & n.25. This suggestion is simply false. 77 Pa. Stat. Ann. §§ 531(3)(i) and 481(a), the provisions cited by respondents in support of this claim, state no such thing. Section 531(3)(i) states only that "a provider shall not require, request or accept payment for the treatment, accommodations, products or services in excess of one hundred thirteen per centum of [various prevailing charges]." Section 481(a), likewise, provides only that "[t]he liability of an employer under this act shall be exclusive and in place of any and all other liability to such employee * * * on account of any injury or death * * * or occupational disease." It is a stretch, to say the least, to read these provisions as precluding employees from voluntarily contracting for other treatment at their own expense. Although 34 Pa. Code § 127.211 and 77 Pa. Stat. Ann. § 531(7) forbid "balance billing" of patients for past treat-

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[19] Although respondents contend that the *Stonebraker* decision supports their balancing of interests under *Mathews*, its holding has been expressly repudiated since the enactment of Act 44. See *Albert Einstein Med. Ctr.* v. *Workers' Comp. App. Bd.*, 707 A.2d 611, 616 & n.11 (Pa. Commw. Ct. 1998) (*Stonebraker* was legislatively superseded by Act 44's utilization review procedures, which minimized the risk that an injured employee will be denied necessary medical care "by establishing a swift and efficient means by which the reasonableness and necessity of medical bills could be determined").

ment determined to be unreasonable or unnecessary,[20] they do not make it unlawful for a worker who knows that such treatment is not covered by workers' compensation to pay for it *prospectively*, at her own expense and on her own initiative.[21] To our knowledge, the law has never been applied in the manner suggested by respondents, and such an interpretation would raise serious constitutional questions. Cf. *Griswold* v. *Connecticut*, 381 U.S. 479 (1965); *Cruzan* v. *Missouri Dep't of Health*, 497 U.S. 261 (1990).

Moreover, as the district court in this case recognized, nothing in the statute "requires that the medical provider stop giving the challenged treatment." Pet. App. 70a n.4. At least half of the named plaintiffs continued to receive disputed care after a request for utilization review. Pet. Br. 42. Respondents' assertion that deferral of payment for disputed care is tantamount to a prohibition on the provision of that care is baseless.

In short, respondents' sparse discussion of the due process balance disregards vital considerations of cost containment and relies on misinterpretations of the law and the record.

CONCLUSION

For the foregoing reasons, and those stated in our opening brief, the judgment of the court of appeals should be reversed.

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[20] "Balance billing" is the practice of collecting from a patient the difference between a physician's charge for medical treatment and the amount reimbursed the patient's insurer. See *Pennsylvania Dental Ass'n* v. *Medical Serv. Ass'n*, 815 F.2d 270, 272 (3d Cir.), cert. denied, 484 U.S. 851 (1987).

[21] The quotation from David Weyl at Resp. Br. 24 n.25, is consistent with this interpretation. Unreasonable or unnecessary care is not "provided under the Act." Medicare draws the same distinction. Although Medicare prohibits "balance billing" patients, a patient who is given advance notice that medical treatment might be deemed unreasonable or unnecessary may agree to pay out-of-pocket for the treatment, and the provider may bill the patient for the care. Statement by Administrator, Health Care Financing Administration, [1998-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 46,018, at 57,031 (Dec. 30, 1997).

Respectfully submitted.

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